Submission No 1

INQUIRY INTO PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

Organisation: Australian Health Services Research Institute, University of Wollongong

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Select Committee
Inquiry into Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020
Legislative Council
Parliament House
Macquarie Street
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Dear Honourable Members

Thank you for the opportunity for the Australian Health Services Research Institute (AHSRI), University of Wollongong to provide a submission to the Select Committee regarding the provisions in the above Bill.

AHSRI is a multidisciplinary research Institute that focuses on generating real-world impact through improving health outcomes for consumers, supporting service providers to explore innovative ways of delivering high quality care and stimulating innovative policy development and health system change. We have over twenty years of research experience investigating the relationship between needs, costs and outcomes in subacute (palliative care, rehabilitation, geriatric evaluation and management, psychogeriatric care) and non-acute (maintenance and supportive) care. This response draws on our extensive work in the aged care and quality improvement fields, and confirms the need for aged care homes to have experienced health professionals, such as Registered Nurses (RNs) and Allied Health (AH) staff, to provide clinical leadership, quality and safe care for residents.

There is clear evidence of a direct relationship between nursing staff mix and quality of care, and of the importance of organisational culture, skill mix and consistency in staffing personnel. Despite this, aged care homes in Australia have progressively experienced a reduction in resourcing in terms of clinical staff (RNs and AH) while at the same time there has been an increase in the complexity of clinical care needs of residents. These changes have arisen in part due to competing regulatory and policy frameworks. The introduction of the *Aged Care Act 1997* reframed residential care from 'nursing home' to the resident's home, effectively justifying a reduction in clinical input and greater reliance on (lower cost) personal care staff. At the same time, there has been a rapid increase in community care options which mean people are now staying longer at home, only entering residential care when they can no longer manage on their own.

The decline in number and mix of qualified (Australian Health Practitioners Regulation Agency – registered) health professionals within aged care has been occurring over several decades. The most recent National Aged Care Workforce Census and Survey (Mavromaras et al. 2017) indicates a reduction in RNs employed from 21% in 2003 to 14.6% by 2016, Enrolled Nurses from 14.4% to 9.3% and Allied Health professionals from 7.6% to 4%. The majority of these positions have been replaced with less skilled, non-clinical personal

care assistants, up from 56.5% in 2003 to 71.5% in 2016 (ACFA 2019, Table 1). Overall staff numbers have also declined, with the proportion of direct care employees dropping from 74% in 2003 to 65% in 2016, with NSW lagging behind other jurisdictions with the ratio of direct care workers to operational places (i.e., residents) at 0.69 compared to the national average of 0.78 (Mavromaras et al. 2017 op cit).

Over the same period, the profile of residents has become increasingly more complex and frail. Around half of all residents have dementia, many are at end-of-life, including some admitted for short-term palliative care, and one in three residents overall die each year. The Resource Utilisation and Classification Study (RUCS) (Eagar et al 2019) we undertook for the Commonwealth Department of Health (DoH) assessed 5000 aged care residents, confirming just how frail, complex and vulnerable residents are, finding:

- Only 15% are independently mobile, and over a third (35%) cannot mobilise at all
- Nearly 90% need assistance with bathing and showering, and 60% need assistance with eating
- Almost three quarters need assistance due to bowel and bladder management issues
- Two thirds of residents need support because of communication problems
- One third had depression (35%) and irritability (35%)
- 43% experienced agitation, expressed through refusal to let others help, being 'uncooperative' or noisy
- 15% of residents were assessed as being highly disruptive

The pivotal role of staffing levels and skills mix in relation to quality outcomes for residents has been confirmed in the international and Australian literature, and through numerous reports commissioned by governments over time (Abt Associates Inc., 2001; ACRC, 2020b; C. Harrington et al., 2012; Hodgkinson, Haesler, Nay, O'Donnell, & McAuliffe, 2011; Institute of Medicine (U.S.), 2001). The Organisation for Economic Co-operation and Development (OECD) long-term care quality framework, for example, identifies three core domains for quality aged care: safety and effectiveness; person-centred and responsiveness; and care co-ordination. These domains are underpinned by three key 'structural inputs', one of which is workforce (including staffing) (OECD/European Commission, 2013). Similarly, a review of over 150 studies of nursing home staffing levels, concluded there was a 'strong positive impact of nurse staffing on both care process and outcome measures' (Charlene Harrington, Schnelle, McGregor, & Simmons, 2016). More recently the Royal Commission into Aged Care Quality and Safety has heard repeated evidence of the impact of poor staffing levels and skills mix on the health and wellbeing of aged care residents, succinctly captured in the title of its Interim Report, 'Neglect' (ACRC, 2019).

To support the Royal Commission in its deliberations, AHSRI was contracted to review how Australian aged care staffing levels compared to international benchmarks (Eagar et al 2020). We identified the USA Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare system was the most comprehensively researched, evidence-based and appropriate method to compare Australian data. The CMS system uses a 5 star rating to define adequacy of care staffing levels. Both RN time and total staff time are rated separately between 1 and 5 stars and cut-off points are regularly updated (CMS 2019). A nursing home receives a 5 star rating if its direct care staffing per resident day is at a level that has been determined as maximising quality outcomes for residents, and residents in care homes that are rated less than 5 stars are at greater risk of reduced quality of care outcomes. The star ratings are based on the casemix adjusted time per resident day. The 'cut points' as at April 2019 are shown in Table 1.

Table 1 CMS staff cut points: minutes per resident day

Staff type	1 star	2 stars	3 stars	4 stars	5 stars
RN	< 19	19 – 30	30 – 44	44 – 63	≥ 63
Total	< 186	186 – 215	215 – 242	242 – 264	≥ 264

Note: Adaption of Table 3 in CMS 2019. Times expressed in portions of hours have been converted and rounded to full minutes.

We applied the CMS methodology to the activity time data collected in Study Two of RUCS, which involved an analysis of structural and individual costs within residential care (McNamee et al. 2019). A surprise finding was how poorly Australia rated compared to services in the US. On average, each Australian resident receives 180 minutes of care per day, of which 36 minutes are provided by RNs. This corresponds to a 1 star level for all care staff (6 minutes below the threshold for 2 stars) and 3 stars for RN staff, with an overall average combined star rating of 2 stars. Using the CMS model, more than half of all Australian aged care residents (57.6%) are in homes that have 1 or 2 star staffing levels, which we view as unacceptable. Of the remaining residents, 27.0% are in homes that have 3 stars, 14.1% receive 4 stars and 1.3% are in homes with 5 stars.

The benefits of appropriate clinical staffing levels and culture within residential aged care has been highlighted throughout the COVID-19 pandemic. A the time of writing, there have been 908 deaths from COVID-19 in the Australia, 685 of which have occurred in residential aged care homes (Health, 2020), one of the highest rates worldwide of deaths in residential aged care as a percentage of total deaths (Cousins, 2020). The Royal Commission's review of COVID-19 in aged care noted a lack of preparedness at both the system (government) and local (care home) levels, compounded by poor staffing levels, in-adequate access to and use of personal protection equipment (PPE), and a highly casualised workforce, contributed to the rapid transmission amongst residents in care homes (ACRC, 2020a). A study from the US also found care homes that were deemed 'high-performing' in terms of nurse staffing levels had fewer COVID-19 cases than low-performing care homes. The authors concluded that 'poorly resourced' care homes that experienced staffing shortages may be more susceptible to the spread of COVID-19 (Figueroa et al., 2020).

The experience of aged care homes in Victoria is particularly telling. All of the 665 aged care residents in that state who died from COVID-19 were from private (non-government operated) care homes. In contrast, the public (government-operated) homes had no deaths or outbreaks, due to mandated RN staff ratios which ensured rapid implementation of effective and sustainable infection control measures.

Conceptualising aged care as a 'lifestyle choice' is no longer appropriate (if it ever was). The frailty and complexity of care needs of residents places them as significant risk of poor health outcomes. In many respects, our aged care homes today are equivalent to the 'non-acute' wards that used to exist in the public hospital system. The absence of clinical nursing skills and leadership in aged care often results in residents having to be hospitalised for complications that could have been otherwise foreseen and resolved within the care home. This causes undue trauma for residents, and unnecessary pressure on public hospitals.

It is clear from the above that there is a need to improve the number of clinical professionals within aged care. However, it is also important to note that staffing needs to be adjusted according to the needs of residents. Only a system that adjusts for the mix of residents (a 'casemix' system) can provide meaningful information to inform the staff numbers and skill mix required in each facility. The current residential aged care funding measure, the Aged Care Funding Instrument (ACFI) is not a casemix system and does not sufficiently discriminate between levels of need. Accordingly, it does not provide a basis on which to determine appropriate staffing levels. The outcome of the RUCS research has been the development of a new funding and classification system for aged care, the Australian National Aged Care Classification (AN-ACC). If fully implemented, AN-ACC will facilitate the meaningful determination of staffing requirements for casemix classes and the systematic measurement and benchmarking of quality within the sector.

Yours sincerely

Professor Kathy Eagar

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